State of Wisconsin
Department of Health and Family Services

SeniorCare Demonstration Program

Operational Protocol

August 30, 2002

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The following attachments were submitted during the CMS site visit on August 21 and August 22, 2002:

#9 "Wisconsin's Medicaid Pharmacy Program"
#10 Revised State-Only Drug Rebate Agreement with Cover Letter to Manufacturers
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SeniorCare
Operational Protocol

A. ORGANIZATION AND STRUCTURAL ADMINISTRATION

The Wisconsin Department of Health and Family Services (DHFS), Division of Health Care Financing (DHCF), is the single state agency that administers the Wisconsin Medicaid program and will also be responsible to implement, monitor and operate SeniorCare.

SeniorCare provides prescription drug and insulin coverage for Wisconsin seniors who are at least 65 years of age and who are not eligible for Medicaid. Through a Section 1115 (a) Demonstration Waiver, SeniorCare will extend Medicaid eligibility under Title XIX to seniors with household income at or below 200 percent of the federal poverty level (FPL). Seniors with household income above 200 percent FPL may also be eligible for SeniorCare, but will not be covered under the demonstration.

Many of the program requirements for SeniorCare correspond to existing Medicaid requirements. These include coverage of prescription drugs and insulin, pricing, rebates, use of Medicaid-certified providers, coordination of benefits with other insurers, and benefits management and cost containment strategies.

The State of Wisconsin will administer the waiver program through the Wisconsin DHFS. Portions of the program may be administered by private entities under contract with the State. The waiver program will use the Wisconsin Medicaid fiscal agent, Electronic Data Systems (EDS), to provide health claims processing, communications, customer service, application processing, and other related services. The Medicaid eligibility agent, Deloitte Consulting, will provide the system capabilities for conducting eligibility determinations.

The DHCF has employed a comprehensive project management approach to ensure timely and successful implementation of SeniorCare, as well as policy and procedure development to ensure long-term operational success. The DHCF brought together key, high-level managers as a Core Team to direct the implementation process, assign responsibilities, and track progress. The Core Team consists of the Bureau Directors for policy and budget, systems and operations, program integrity and eligibility. This approach provided the structure necessary to identify and resolve issues quickly throughout the implementation process.

The Core Team developed a detailed project work plan identifying deliverables and due dates. All key due dates have been met, and the project remains on-schedule. DHFS began to accept SeniorCare applications on July 1, 2002, and benefit coverage will commence on September 1, 2002. Several of the project planning documents, including the work plan, are included as Attachments 1 and 2.

The DHCF has also worked closely with a SeniorCare Advisory Committee to solicit feedback and advice regarding key aspects of implementation. The Advisory Committee is comprised of individuals who represent consumers, tribal members, senior agencies and organizations, providers and manufacturers. The Committee has met monthly since January and, between meetings, DHCF has worked with subsets of the Committee on time-sensitive issues. A list of Advisory Committee members is provided as Attachment 8.

In order to ensure continuity and consistency with non-demonstration Medicaid, SeniorCare will be implemented, monitored and operated using the general organizational structure of the DHCF and the existing Wisconsin Medicaid program. The DHCF has requested nine additional FTE to support the demonstration-required tasks and SeniorCare ongoing operations. These staff will be assigned to one of five existing Bureaus, based upon the work they will perform. Each Bureau, which is responsible for specific areas of program administration, is described below.

Bureau of Fee-For-Service Health Care Benefits

The Bureau has primary responsibility for developing Medicaid policies for all services for which the State directly reimburses Medicaid providers. The Medicaid program provides direct provider reimbursement for approximately 35 service areas such as nursing home, physician, hospital, dental, and pharmacy services. The Bureau's responsibilities include completing policy analysis and development, determining the scope of benefits, benefit limitations, and rates of payment. The Bureau is also responsible for maintenance of the Medical Assistance State Plan and Administrative Rule and for staffing the Medical Assistance Advisory Committee. In addition, the Bureau administers a variety of health care programs for special populations that do not qualify for Medicaid, including the WisconCare Program, General Relief-Medical, and the Chronic Renal Disease Program.

Bureau of Health Care Systems and Operations

This Bureau is responsible for implementation, operation and monitoring of systems, procedures, reports and contracts necessary to support the administrative requirements and activities of Division of Health Care Financing programs, including claims processing and operations through the Medicaid Management Information System (MMIS). This Bureau also manages the Medicaid Fiscal Agent contract and operates several programs to identify and recover payments through coordination of benefits, estate recovery, and drug rebate.

Bureau of Health Care Program Integrity

This Bureau has responsibility for ensuring compliance with Medicaid policies and procedures, identifying areas of non-compliance, recovering overpayments, prior authorization, and medical audits and reviews. With respect to the SeniorCare program, the Bureau will assume monitoring and oversight functions for certifying/de-certifying providers, conducting provider audits and participant interviews to evaluate compliance

with SeniorCare requirements, responding to consumer complaints, providing clinical input to SeniorCare decision making, and preparing annual reports to the Legislature regarding provider participation in SeniorCare.

Bureau of Health Care Eligibility

The Bureau of Health Care Eligibility is responsible for developing and administering eligibility policies and programs, including associated education and outreach activities for Medicaid, BadgerCare, SeniorCare and numerous other sub-programs of Medicaid that are administered by the Division of Health Care Financing. Eligibility policy for these programs is implemented through complex automated systems, including Client Assistance for Reemployment and Economic Support (CARES) (for eligibility determination), MMIS (the Medicaid management information system), and the State Data Exchange with the Social Security Administration.

The Bureau has oversight responsibility for the local administration (application processing, eligibility determinations, annual reviews, change reporting) of Medicaid eligibility. For SeniorCare, the Bureau oversees the state administration of SeniorCare which includes responsibility for systems development, application development and distribution, customer service, training and supervision of state staff responsible for eligibility determinations and application processing, and the development and distribution of public education and outreach materials. Overall, the Bureau is responsible for managing comprehensive outreach and public education initiatives to assure that the public is aware of programs that offer health care coverage for low-income people to improve the health status of Wisconsin's population.

The Bureau works closely with a wide array of federal, state and local agencies to ensure the equitable and efficient administration of these programs.

Bureau of Managed Health Care Programs

The Bureau of Managed Health Care Programs has primary responsibility for administration and oversight of all Medicaid managed care programs. The Bureau has primary responsibility for oversight and quality assurance activities associated with delivery of medical services through HMOs. Additional responsibilities include HMO capitation and insurance premium rate setting, and federal waiver development for new and innovative managed care programs. Other programs administered by the Bureau include BadgerCare and the Health Insurance Risk Sharing Plan (HIRSP). HIRSP includes a separate drug benefit, administered by this Bureau. The Bureau will have a key role in the administration of SeniorCare. A SeniorCare Program Manager, who also has expertise in and responsibility for the administration of HIRSP, will be appointed within the Bureau, which will be responsible for related budget monitoring and federal waiver reporting.

Claims Processing

SeniorCare claims will be processed through the Medicaid Point-of-Sale, or POS, system. Wisconsin Medicaid-certified pharmacy providers are familiar with this on-line, real time claims adjudication system. Modifications to the POS will allow the system to not only process and price claims correctly, but to track entered, covered claims against an individual's spenddown or deductible obligations. Please refer to Section F, Benefit and Cost Management Methods, for additional information regarding the POS system.

Pharmacy Benefits Management Approaches

SeniorCare will apply the same rigorous and effective pharmacy benefits management strategies used by Wisconsin Medicaid to enhance the quality of care and cost-effectiveness of the program. These pharmacy benefits management strategies, which are listed below, are described in Section F, Benefit and Cost Management. A paper entitled "Wisconsin Medicaid's Pharmacy Program" provides additional information and is provided as Attachment 9.

- Retrospective Drug Utilization Review
- Prospective Drug Utilization Review
- Maximum Allowable Cost List Pricing
- Pharmaceutical Care
- Prior Authorization
- Diagnosis Restrictions and Excluded Drugs
- Maximum Daily Supply Limits

Reimbursement Rates & Dispensing Fees

SeniorCare payment rates are set in statute. For all participants covered by the demonstration, and for non-demonstration-covered participants above 200% FPL and below 240% FPL, the reimbursement rates will be the Medicaid rate plus 5 percent, plus a dispensing fee equal to the Medicaid dispensing fee. Medicaid reimbursement for legend drugs is the lesser of:

- Average wholesale price (AWP) less 11.25%, plus a dispensing fee, for most brand drugs;
- The maximum allowed cost (MAC), plus a dispensing fee, for multi-sourced branded and generic drugs; or
- The usual and customary amount as billed by the pharmacy to private pay clients.

The POS system will calculate the correct SeniorCare payment rate and inform the provider how much to collect from the participant.

Enrollee Cost-Sharing Collections

As indicated in Section D, Cost Sharing Protections, there are three components of enrollee cost-sharing for participants covered by the demonstration. These cost-sharing provisions, which are summarized below, are specified in the statutory language for the SeniorCare program.

- Annual Enrollment Fee: All participants will be required to pay an annual enrollment fee of $20. According to state law, this enrollment fee is a condition of eligibility. Applicants are instructed to submit a completed, signed application along with the $20 enrollment fee.
- Deductible: Participants with income above 160 percent of the federal poverty level (FPL) and at or below 200 percent of the FPL are responsible for the first $500 of prescription drug costs per year. This is the SeniorCare deductible. (Participants with income at or below 160 percent of the FPL are not required to pay the first $500 of prescription drug costs.) Participants will meet this deductible obligation by paying the pharmacy directly for the first $500 of SeniorCare-covered drugs purchased during the 12-month benefit period.
- Co-payments: For participants with income at or below 160 percent of the FPL, and for participants with income above 160 percent of the FPL who have met the $500 annual payment, a co-payment is required for each prescription drug for the remainder of that 12-month period. The co-payments ($15 per prescription for covered brand name drugs and $5 per prescription for covered generic drugs) will be paid by the participant to the provider at the time of purchase. The SeniorCare program will reimburse the pharmacy for the balance up to the SeniorCare allowed amount.

According to state law, non-demonstration-covered participants above 240% FPL, will pay the retail rate charged by the pharmacy until they "spend down" to meet the income limit of 240 % FPL. Once these individuals spend down to 240% FPL, the reimbursement rates referenced above will apply.

The POS system will inform the provider how much to collect from the participant depending upon each participant's spenddown, deductible or co-payment obligations.

Rebate Agreements

SeniorCare legislation intends that the program cover prescription drugs produced by drug manufacturers that enter into a rebate agreement with the state. Rebates will be collected only when SeniorCare issues reimbursement for a covered prescription drug, i.e., rebates will not be collected for drugs obtained by a participant in his or her deductible period. The existing federal Medicaid rebate agreements will apply for persons covered under the demonstration.

The State has issued separate state-only rebate agreements to cover prescription drugs dispensed to participants not covered by the demonstration, i.e. those participants whose income exceeds 200% FPL. Consistent with state law, the terms of these rebate

agreements mirror the federal Medicaid rebate agreements and the state will use the same process to collect rebates under these separate agreements. A copy of the separate agreement is provided as Attachment 10. These rebate agreements are necessary to ensure that all SeniorCare participants have access to the same drug benefits.

As of August 20th, we received 171 signed rebate agreements out of the 558 that we issued. Forty-four manufacturers have informed us that they will not participate. While many of these produce over-the-counter drugs not covered by SeniorCare, we are asking those that manufacture prescription drugs to reconsider. We are aggressively pursuing the remaining manufacturers to urge them to sign the rebate agreements. (See Attachments 11 and 12)

B. REPORTING ITEMS

Monthly Progress Calls

(Reference: Terms and Conditions Section I, number 7.) Before and for six months after implementation, DHCF and CMS will hold monthly calls to discuss demonstration progress. After six months of operation, DHCF and CMS will determine the appropriate frequency of progress calls.

Quarterly and Annual Progress Reports

(Reference: Terms and Conditions Section I, number 8.) DHCF will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. DHCF's report will address, at a minimum, the following:

- a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures)
- notable accomplishments
- problems/issues that were identified and how they were solved

Final Report

(Reference: Terms and Conditions Section I, number 9.) At the end of the demonstration, DHCF will submit a final draft report to CMS for comments. CMS' comments shall be taken into consideration by DHCF for incorporation into the final report. DHCF will submit the final report, with CMS' comments, no later than 180 days after the termination of the project. The report will include a discussion of the evaluation results.

Financial Reporting

The budget neutrality agreement under this demonstration requires the state to capture and report financial expenditures in accordance with the special terms and conditions for 1)individuals enrolled in the demonstration (demonstration enrollee) and 2)the non-

demonstration aged. This section of the operational protocol describes the policies and procedures that are necessary to implement the financial reporting requirements in Attachment A of the Special Terms and Conditions.

Wisconsin will modify its Medicaid Management Information System (MMIS) for the SeniorCare population in order to facilitate expanded expenditure and budget reporting to CMS for the following reporting objectives:

- Reporting/claiming Federal Financial Participation (FFP);
- Tracking against the 1-year expenditure targets and the 5-year FFP cap;
- Estimating/Budgeting;
- Distinguishing expenditures separately for the individuals enrolled in the demonstration and for the non-demonstration aged populations; and
- Distinguishing expenditures by date of service to report expenditures in the correct demonstration year.

The Medicaid and State Children's Health Insurance Program Budget and Expenditure System - (MBES/CBES)

Reporting Waiver Budget Requests on the CMS-37

All estimated demonstration budget requests related to the budget neutrality agreement will be reported on the State's quarterly CMS-37 budget report via the MBES/CBES. After entering this system, the State will access the appropriate forms by selecting the CMS-37 system button on the left side of the screen. The State will select the function "add/modify", then select the appropriate waiver reporting form for the demonstration enrollees from the drop down menu provided at the bottom of the screen. This drop down menu will provide access to all CMS-37 Medicaid Program Budget Report forms for Medical Assistance Payments and for Administrative Payments. Once the Wisconsin has completed its estimate of **total expenditures** for the quarter, it will separately report the estimated expenditures for each demonstration as included in and reported on the CMS-37.12 (Other Narrative Explanations) for both MAP and ADM as included in and reported on the CMS-37. Once the Form CMS-37.12 has been selected, Wisconsin will identify the demonstration by its appropriate number and break down the estimate by total computable and federal share for each budget year as identified for the budget cycle.

Reporting Waiver Expenditures on the CMS-64

All claims related to the budget neutrality agreement will be reported on the State's quarterly CMS-64 expenditure report via the MBES/CBES. After entering this system, the State will access the appropriate forms by selecting the CMS-64 button on the left side of the screen. The State will select "add/modify", then select the appropriate waiver

reporting form for the demonstration enrollees from the drop down menu provided at the bottom of the screen. This drop down menu will provide access to the reporting Forms CMS-64.9 WAIVER, CMS-64.9P WAIVER, CMS-64.10 WAIVER, and CMS-64.10P WAIVER. These forms add directly into the CMS-64 Summary Sheet. This insures that the State will receive Federal match for all title XIX demonstration enrollee waiver expenditures. Once the appropriate form has been selected and entered, the State will either select the "add" bar to add a new waiver sheet or the "modify" bar to modify a waiver sheet that has already been entered into the system. Once this selection has been made, the next screen will provide a chart of all waivers for Wisconsin. The chart provides information for each waiver by Waiver Type, Waiver Number, and Waiver Name. The waiver type column includes 1115, 1915(b), and 1915(c) waivers. The next column provides the waiver number. For 1115 waiver numbers, a block is included that needs to be completed with the correct demonstration year (i.e., -01, -02, -03, etc.). The demonstration year entered into the system will be the demonstration year in which services were rendered or for which capitation payments were made. Lastly, the list is grouped by waiver name. The waiver name consists of those eligibility groups or reporting categories identified in the Special Terms and Conditions and/or Operational Protocol. The eligibility groups for this demonstration will be identified as 1) ***demonstration enrollee*** for individuals enrolled in the demonstration or 2) ***non-demonstration aged***. A separate CMS-64.9 WAIVER and/or CMS-64.9P WAIVER will be completed for each eligibility group covered under the SeniorCare budget neutrality agreement.

All capitation payments will be reported on line 18.A. of the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER. All fee-for-service (FFS) expenditures will be reported on the appropriate service line on the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER.

In order to achieve the necessary expenditure tracking by demonstration year, the last two digits of the "WAIVER NUMBER" data entry field will be extremely critical. The demonstration year is included as a part of the "WAIVER NUMBER" and is identified as a part of the extension. For example, Wisconsin's waiver number is 11W00149/ with the extension of 5-xx. The 5 represents the Chicago Region and the xx represents the demonstration year.

> EX: Assume the implementation date was April 1, 1999. Expenditures reported for the quarter ended March 31, 20XX will be broken out by date of service and assigned to the correct demonstration year (/5-0X (current year) or /5-0X-1, etc.) on the current quarter expenditure report (03/31/XX). Capitation payments made in that same quarter (March 31, 20XX) for services covered in April 20XX will be claimed on the current quarter expenditure report (March 31, 20XX), but will be assigned to the next demonstration year (/5-0X+1).

Tracking of expenditures against the annual expenditure targets and the 5-year cap will begin July 1, 2002 and end on June 30, 2007. The "first demonstration year" (demo year –01) for budget neutrality purposes will be defined as extending from July 1, 2002 through June 30, 2003. For expenditures being claimed for dates of service beginning

July 1 of each succeeding demonstration year, replace the last two digits with -02 through -05, respectively. In this way, Wisconsin and CMS will be able to track the 1115 demonstration expenditures to the correct year of the expenditure target/cap. The expenditures for each demonstration year will be automatically accumulated on the CMS-64 Waiver Expenditure Report - Schedule C. The State will access this report on a quarterly basis to monitor its expenditures under the budget neutrality cap.

> For the SeniorCare demonstration enrollees, all offsetting adjustments attributable to the budget neutrality agreement that would normally be reported on lines 9 or 10.C. of any CMS-64 will be reported on line l0.B. The MBES/CBES system does not allow for these adjustments to affect waiver expenditures. Therefore, in order for these adjustments to be credited to the State's 1115 waiver expenditures, these offsets must be reported on line 10.B. and identified with the correct waiver information. This will allow these claims to be included in the CMS-64 Waiver Reports (Schedules A, B, and C) that the State will access and use as a tracking mechanism. Waiver Schedule A will provide waiver expenditures claimed for the current quarter. Waiver Schedule B will provide a cumulative total for previous waiver expenditures as reported, current quarter expenditures, and the total expenditures to date. Waiver Schedule C provides a breakout of waiver expenditures to date by WAIVER NAME, by demonstration year, and totals for both Total Computable (TC) and Federal Share (FS). For any other cost settlements (i.e., those not attributable to the budget neutrality agreement), the adjustments will be reported on lines 9 and 10.C., as instructed in the State Medicaid Manual.

(Reference: Terms and Conditions - Attachment A, number 4.) For the purpose of calculating the budget neutrality expenditure cap, an enrollee is defined as any individual that is enrolled for one or more days during the calendar month. Therefore, the member months are counted for any individual that is enrolled for at least one day during the month.

Wisconsin will submit Medicaid eligibility and claims information to CMS through the Medicaid Statistical Information System (MSIS).

(Reference: Terms and Conditions – Attachment A, number 4.a.) Administrative costs attributable to the waiver include:

- Time reported by staff assigned SeniorCare support responsibilities;
- Ongoing costs incurred for SeniorCare applicants and enrollees in the CARES eligibility system;
- Ongoing costs incurred for the SeniorCare applicants and enrollees in the MMIS system;
- Ongoing costs incurred for the SeniorCare applicants and enrollees in state systems;
- Additional ongoing costs may arise as they are identified; and

- Costs associated with policy and systems design necessary to implement SeniorCare.

(Reference: Terms and Conditions – Attachment B) Wisconsin will provide information on a quarterly basis regarding the amount of payments made to providers both inside and outside of the demonstration budget neutrality cap.

C. COST-SHARING

Participants in the program will be required to comply with cost-sharing provisions that vary by income level. The cost-sharing provisions, including the dollar amounts, are specified in the statutory language for the SeniorCare program.

Cost-Sharing Features

Annual Enrollment Fees. All participants will be required to pay an annual enrollment fee of $20.

Annual Costs For Certain Participants. Certain participants will pay the first $500 in prescription drug costs each enrollment period (called the deductible).

Participants with income above 160 percent of the federal poverty level (FPL) and at or below 200 percent of the FPL are responsible for the first $500 of prescription drug costs per year. Participants with income at or below 160 percent of the FPL are not required to pay the first $500 of prescription drug costs.

Co-payments. For participants with income at or below 160 percent of the FPL, and for participants with income above 160 percent of the FPL who have met the $500 annual payment, a co-payment is required for each prescription drug for the remainder of that 12-month period. The following co-payments apply:

- Participants are required to pay a $15 co-payment per prescription for covered brand name drugs.
- Participants are required to pay a $5 co-payment per prescription for covered generic drugs.

Reporting of Cost-Sharing to CMS

Enrollment fees and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the demonstration will be reported to CMS on the CMS-64 Summary Sheet. This will allow CMS to share in the collection of such fees. The State will also separately identify these fees on the narrative form of the CMS-64. The State will work with CMS to coordinate which enrollee cost-sharing information will be reported.

Any enrollee cost-sharing collections for the demonstration population will be used appropriately to reduce program expenditures prior to determining the level of FFP.

Informing Enrollees and Providers of Enrollee Financial Obligations

Enrollees are informed of financial obligations in a variety of ways. First, our outreach materials contain information about enrollee cost-sharing requirements under SeniorCare. These materials include the marketing brochure, the fact sheets and other information on the web site. In addition, seniors can obtain information directly from the Department by calling the SeniorCare Customer Service Hotline. Further, a pre-application guide has been developed. This guide is a web-based interactive tool that assists seniors in determining what income to count and what cost-sharing they might have if they apply for SeniorCare based on the income information entered. Finally, we have conducted a series of presentations and training sessions throughout the state. All of our presentations explain the enrollee cost-sharing requirements under the program.

Once enrolled, participants will receive a notice of eligibility. The notice will inform each participant of his/her cost-sharing responsibilities. The Participant Handbook, mailed to each participant, will also specify the cost-sharing requirements for the program. In addition, the point-of-sale system will track the person's deductible. Thus, participants can also find out what their particular cost-sharing obligations are and how much has been paid toward their deductible by asking their pharmacist. Finally, participants can always request a statement of their SeniorCare benefits, which will include their cost-sharing requirements and how much has been paid by the participant.

Providers will be trained about the cost-sharing requirements under the program. Again, through the point-of-sale system, providers will have real-time, on-line information about a customer's SeniorCare benefits and cost-sharing. In addition, providers can call the Provider Hotline (separate from the Customer Service Hotline), if they have questions.

D. COST-SHARING PROTECTIONS

Cost-Sharing Requirements

Enrollment Fee. According to the state law, the enrollment fee must be paid prior to being determined eligible for the program. If a person has not submitted the enrollment fee with the application, he/she will receive a notice indicating that his/her application is pending because he/she did not send in the required enrollment fee. Once the fee is paid, the Department can complete the application process and enroll the individual in the demonstration if all other eligibility requirements are met.

Deductible. Payments toward the deductible are counted as the drug is purchased at the pharmacy. If the person does not pay his/her share of the drug cost at the time of purchase at participating pharmacies, the costs cannot be counted toward the person's $500 deductible. During the deductible, covered prescription drugs may be purchased from participating pharmacies at a rate that is equal to the Medicaid reimbursement rate plus 5% plus a dispensing fee equal to the Medicaid dispensing fee.

Co-payment. The co-payment also must be paid at the time the drug is received. If the person does not pay the co-payment, the pharmacist can choose not to dispense the drug.

As a result of these provisions, participants cannot be disenrolled for failure to pay the cost-sharing, because the cost-sharing is required prior to drug dispensing.

Notice

For applications received between July 1, 2001 and August 31, 2001, eligibility will be determined as soon as possible for benefits beginning September 1, 2001. The Department will determine a person's eligibility for SeniorCare as soon as possible for applications the Department receives on or after September 1, 2002, but not later than 30 days from the date the Department receives a signed application that contains, at a minimum, the name and address of the applicant. If a delay in processing the application occurs because it is necessary to secure additional information from the applicant, the Department will inform the applicant in writing of the delay.

If an applicant does not submit the $20 enrollment fee with his or her application, the person will receive a notice indicating that if the enrollment fee is not submitted within the 30-day processing period, the person's eligibility will be denied. If the person is denied for failure to pay the enrollment fee, the person will receive a second notice that will indicate that the application has been denied because they did not pay the enrollment fee. Both notices will inform the applicant that he or she may re-apply.

Upon a determination of eligibility all enrollees will receive a letter notifying them of their eligibility and, if eligible, their cost-sharing requirements. The letter will be sent the first business day following the determination of eligibility. Eligibility will be effective the first day of the month following the month in which all eligibility criteria are met. The notice will contain the participant's rights and responsibilities. All enrollees will be notified of their option to decline participation at any time. If the person notifies the Department within the 30-day processing period, or 10 days from the date the Department sends the notice, whichever is later, that he/she wishes to decline participation, the Department will refund the enrollment fee paid for that benefit period. If a person has paid the annual enrollment fee with his or her application, and is determined ineligible for the program, the Department will also refund the paid enrollment fee. The enrollment fee will not be refunded in most other circumstances in which the participant declines to participate once enrolled.

E. COORDINATION WITH PRIVATE HEALTH INSURANCE COVERAGE

In Wisconsin, historically only 5 percent of Medicaid-eligible seniors have verified prescription drug coverage. Given the income levels allowable under SeniorCare, it is anticipated that the percentage will be somewhat higher among SeniorCare participants, but it is unclear how much higher. The existence of private prescription drug coverage does not preclude SeniorCare eligibility.

Obtaining Private Insurance Coverage Information

Private prescription drug coverage will not be self-reported or available through CARES, The one-page application for SeniorCare does not request insurance information and the application process does not involve an interview at the county. The primary source for information about prescription drug coverage will be Insurance Disclosure, as is the case under Medicaid. With Insurance Disclosure, commercial carriers encompassing over 90 percent of policies sold to Wisconsin residents send monthly electronic lists of covered individuals to Medicaid. These lists are compared to Medicaid-eligibility files and, where matches are found, insurance information is applied to the eligibility file. This process will be expanded for SeniorCare participants. For insurance carriers that are not part of the Insurance Disclosure process, we accept information about insurance coverage from providers using an existing insurance information form and from participants through customer service. We will verify this information directly with the insurer. We also will use existing insurance information for participants who were previously eligible for Medicaid but now qualify for SeniorCare..

Coordination of Benefits

Unlike most Medicaid programs, Wisconsin Medicaid cost avoids pharmacy claims, in advance, when verified prescription drug coverage is known to exist and the carrier is on a specified list of those which providers can efficiently bill online for non-Medicaid recipients. These include managed care plans as well as the majority of drug processors and insurance plans. When billing through the Point-of-Sale (POS) system, if there is no indication that the carrier was previously billed, the claim is immediately denied and the provider is informed which carrier they need to bill. The identical process will apply to claims made on behalf of SeniorCare participants.

If verified drug coverage becomes known subsequent to claim payment, or if a known carrier is not on the specified list, Wisconsin will "pay and chase" for SeniorCare. We will use the similar process as Medicaid, where we will bill the insurer directly to recover costs paid by SeniorCare.

As described in the SeniorCare waiver application, crowd out of private insurance is not expected. SeniorCare is created to address crowd out as described below:

Seniors can enroll and participate in SeniorCare without dropping their private insurance. SeniorCare will coordinate benefits with private insurance.

SeniorCare benefits are limited to prescription drug coverage and participants are unlikely to drop their private insurance that has broader coverage than SeniorCare.

Due to the 240% of the FPL limit or spenddown provision, it is not expected that many pension plans will be induced to drop pharmaceutical coverage, since it would leave many enrollees over 240% of the FPL without a viable option for prescription drug coverage.

SeniorCare's cost sharing provisions are higher than normally found in Medicaid programs. In fact the cost sharing benefits are similar or even more expensive than those found in private insurance coverage. As a result, there is less individual incentive to drop current coverage for the waiver program.

Most private insurance policies cover more than just prescription drugs, so there are fewer policies limited to prescription drug . Crowd-out is less of a potential problem simply because there is less to crowd out.

We have strongly encouraged seniors to seek assistance from benefit specialists in the Wisconsin Aging Network for advice on decisions regarding their private insurance and SeniorCare enrollment.

Based on feedback from advocates and seniors, seniors may be reluctant to drop private insurance because of skepticism of a state funded prescription drug program.

Impact of Private Insurance Payments

Private insurance payments will be used to calculate the amount SeniorCare will allow on claims with private insurance. Reimbursement amounts for claims will be the lower of the pharmacy's usual and customary charge billed on the claim, the SeniorCare rate or the private insurance payment plus the participant's private insurance cost sharing amount. Other insurance payments and SeniorCare cost sharing amounts will be subtracted from the allowed amount to determine the remaining amount, if any, that would be paid on a SeniorCare claim for a participant with private insurance.

Deductible Period. Any amount paid by insurance will reduce the out-of-pocket cost to the participant dollar-for-dollar, which should work to encourage seniors to retain their existing private prescription drug coverage. Any cost-sharing obligation related to the private policy will count toward the participant's SeniorCare deductible amount.

Co-payment Period. The amount paid by SeniorCare will be reduced by the amount insurance paid. The participant will not be required to pay a higher private insurance cost-sharing amount (co-payment or deductible) than the $5.00 or $15.00 required under SeniorCare even if the private policy has a higher cost-sharing amount. The SeniorCare claims processing and pricing system is designed to calculate the amount of participant cost sharing based on the private insurance cost sharing amount indicated by the pharmacy on the claim. In the co-payment period of participation the system will compare the private insurance costsharing amounts to the SeniorCare co-payments and will enforce co-payments by reporting to the pharmacy via POS or the remittance report, no more than the $5.00 or $15.00 SeniorCare co-payment. The SeniorCare co-payments are deducted from the payment to the pharmacy and the pharmacy is instructed to collect the co-payment from the participant. Co-payment amounts and requirements for pharmacists to collect them is also enforced through administrative rule. Post payment review by Program Integrity will also monitor to assure pharmacies are collecting the correct amounts from participants.

F. PHARMACY SERVICES, PROVIDERS, AND BENEFIT MANAGEMENT

Benefits

Wisconsin Medicaid covers legend (prescription) drugs prescribed by a licensed physician, dentist, podiatrist, nurse prescriber, or optometrist. In addition, physicians may delegate prescription authority to a nurse practitioner or physician assistant.

Wisconsin Medicaid has an open drug formulary. Legend drugs are covered if they meet all of the following criteria:

- The drug is FDA-approved;
- The manufacturer signed a rebate agreement with the Health Care Financing Administration (now Centers for Medicare and Medicaid Services); and
- The manufacturer has reported data and prices to First DataBank.

SeniorCare statutes define prescription drugs as prescription drugs covered by Wisconsin Medicaid and for which the drug manufacturers enter into a rebate agreement with the State. However, like Wisconsin Medicaid, which covers certain over-the-counter drugs, SeniorCare will extend coverage to insulin. SeniorCare benefits are the same for all participants in the SeniorCare program, regardless if the participant is in the deductible period or is using co-payments for their cost-sharing requirement. SeniorCare will provide service to participants on a fee-for-service basis.

Provider Network

Pharmacies currently enrolled in the Wisconsin Medicaid program will fill prescriptions for SeniorCare waiver program participants as well. Access to pharmacies for the SeniorCare waiver program will be readily available as more than 95 percent of licensed pharmacies in Wisconsin participate in the Wisconsin Medicaid program. Pharmacists who participate in the Wisconsin Medicaid program are required to also participate in the SeniorCare waiver program.

Rates

Medicaid reimbursement for legend drugs is the lesser of:

- Average wholesale price (AWP) less 11.25 percent, plus a dispensing fee for most brand drugs;
- The maximum allowed cost (MAC), plus a dispensing fee, for multi-sourced branded and generic drugs; or
- The usual and customary amount, as billed by the pharmacy to private pay clients.

SeniorCare payment rates are set in statute at the Medicaid rate plus 5 percent, plus a dispensing fee equal to the Medicaid dispensing fee. The allowed amounts are approximately 20 percent less than standard retail rates. SeniorCare legislation requires

automated transmission of rates to providers. Pharmacies are prohibited from charging enrollees an amount that exceeds the allowed amounts set in statute.

The SeniorCare program was established with the input of representatives from a broad range of stakeholders, including health-care providers, pharmacies, consumer-advocate groups, and the pharmaceutical manufacturing industry. Provisions related to program payment rates were established to ensure the success of the SeniorCare program in terms of patient access to services, consistency with the Wisconsin Medicaid program, and participation of recipients, pharmacies, and manufacturers.

Benefit and Cost Management Methods

To further enhance the primary health care benefits and the cost-effectiveness of the SeniorCare waiver program, the Department plans to implement a number of management strategies to enhance the quality of care and cost-effectiveness within the waiver program. These benefit management strategies, which are currently used in the State Medicaid program, will be extended to SeniorCare and include the following:

a) Pharmacy Point-of-Sale (POS). Wisconsin Medicaid implemented a pharmacy point-of-sale electronic claims management system for Medicaid fee-for-service providers statewide beginning September 22, 1999. The POS system enables providers to submit real-time claims electronically for legend and over-the-counter drugs for immediate adjudication and eligibility verification. The real-time claims submission verifies recipient eligibility, including other health insurance coverage, and monitors Medicaid drug policies. Claims are also screened against recipient medical and prescription history within the Medicaid system. Once these processes are complete, the provider receives an electronic response indicating payment or denial within seconds of submitting the real-time claim.

   The following have occurred since the implementation of POS:

   - POS permits pharmacies to submit claims and receive notification of coverage before drugs are dispensed.
   - Currently, most of the state's 1,100 pharmacies are participating in real-time transactions. As many as 30,000 real-time Medicaid transactions are processed every day.
   - The average system response time is 0.4 seconds. Of all drug claims received by Medicaid, 90 percent to 95 percent are submitted real-time.
   - Claims with "other health insurance" listed must be billed to that other insurance first.
   - Wisconsin continues to be one of the few states in the country that denies claims up front if records indicate the recipient has other health insurance that pays for drugs.
   - Claims for the same drug on the same day by one recipient at different pharmacies are denied because claims history is updated real-time, and all Medicaid pharmacy claims are reviewed.

b) Drug Utilization Review. The federal Omnibus Budget Reconciliation Act of 1990 (CFR Section 456.703-456.705) calls for a Drug Utilization Review (DUR) program for all Medicaid outpatient drugs in order to improve the quality and cost-effectiveness of recipient care. There are three components to the Medicaid DUR program: prospective DUR, retrospective DUR, and an educational program.

Prospective DUR. The Medicaid prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. These problems include therapeutic duplication, drug/drug interactions, early and late refills, cumulative side effects, and drug contraindications for pregnancy, certain diseases, and specific ages. Our DUR system does have alerts specific to the elderly. Alerts such as drug/drug interaction, therapeutic duplication and cumulative side effects are likely to occur more frequently in the elderly population since they tend to take more drugs. Drug disease contraindication is also more likely to occur in the elderly population since elderly individuals tend to have more chronic disease than young individuals. The prospective DUR system reviews all drug claims for an individual participant regardless of the pharmacy in which a prescription was filled. Alerts are issued which will allow pharmacists to review the patient's entire profile and evaluate, in consultation with the patient's physician, whether or not the drug should be dispensed. This will find and prevent many potential medication problems thus decreasing emergency room visits and hospitalizations. Attachment 13 is a description of the frequency of our prospective DUR alerts.

Retrospective DUR. The Medicaid retrospective DUR program provides for the ongoing periodic examination of paid claims data and other records in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care associated with specific drugs or groups of drugs. SeniorCare participants are reviewed for the Lock-in program using the same procedures as Medicaid. Attachment 14 is a copy of the Medicaid Lock-in procedure. Wisconsin Medicaid will continue to look for trend data among physicians and pharmacists through retrospective DUR.

In addition, Retrospective DUR interventions provide patient specific information directly to prescribers. This intervention includes a letter describing the potential drug problem, a complete patient drug history for the past year, and a response form. The response form requests the physician to inform us about how the problem identified has been addressed and also provides the prescriber an opportunity to rate the usefulness of the information. Previous experience in the Medicaid program results in a 66% response rate and 75% of responders indicate that the information provided is useful or very useful.

Educational Program. DHFS uses DUR program data to educate prescribers and dispensers on common drug therapy problems with the aim of improving prescribing and dispensing practices.

Individual pharmacies are responsible for prospective DUR. Wisconsin Medicaid is responsible for providing the retrospective DUR program and the educational program. As required by the Omnibus Budget Reconciliation Act of 1990, a Medicaid DUR Board comprised of practicing physicians and pharmacists from around the state, has been appointed to oversee the entire Medicaid DUR program. The Wisconsin Medicaid DUR Board reviews and approves all criteria used for both prospective and retrospective DUR.

Wisconsin uses a variety of methods to provide educational programs. These include letters to prescribers and recipients, and Provider Updates. Feedback from the DUR programs, from prescribers, or from reviews of current medical literature as well as changes in the drug market may point out the need for additional information for prescribers and dispensers of drugs. Educational newsletters are developed to address these issues. The DUR Board then reviews these educational materials. Examples of these educational materials are included in Attachment 15.

c) Maximum Allowed Cost (MAC) List. The federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issues a drug list at least two times a year. This list includes drugs that are available generically from at least three companies as well as a recommended maximum allowed cost (MAC). In addition, states may have their own MAC lists and set prices differently from the CMS issued prices, as long as the overall amount spent for generic drugs is no more than it would have been using the CMS prices.

   Wisconsin Medicaid issues its MAC list quarterly and has one of the most extensive MAC lists in the country. SeniorCare will also use the Wisconsin Medicaid MAC list. If a product is available generically, Wisconsin Medicaid generally adds it to the state's MAC list. Maximum prices allowed are based on prices for which drugs are readily available through wholesalers in Wisconsin. When a drug is on the MAC list, Wisconsin will only reimburse the generic price, unless the prescriber writes "brand medically necessary" on the prescription. Less than 2 percent of Wisconsin Medicaid prescriptions currently indicate that the brand is medically necessary. In addition, because Wisconsin's MAC list is more extensive than the CMS list, the savings to the state are considerably higher than they would be using the CMS list alone.

d) Pharmaceutical Care. Wisconsin's Medicaid's Pharmaceutical Care (PC) program provides pharmacists with an enhanced dispensing fee for PC services provided to Wisconsin Medicaid recipients. The enhanced fee reimburses pharmacists for additional actions they take beyond the required dispensing and counseling for a prescription drug. A PC profile must be created and maintained for the recipient prior to submitting a PC claim. It must include the intended use or diagnosis information for each drug that the recipient is actively using.

   Reimbursement for the PC dispensing fee requires that pharmacists meet all basic requirements of federal and state law for dispensing a drug plus completion of specified activities that result in a positive outcome both for the recipient and the Medicaid program. Positive outcomes include increased patient compliance and prevention of potential adverse drug reactions.

e) Prior Authorization. Under prior authorization (PA), Wisconsin Medicaid requires pharmacists to receive approval for certain drugs from the Department before reimbursement is provided. PA may be done electronically for most drugs requiring PA. Wisconsin requires drug prior authorization for the following reasons:

- Potential drug abuse or misuse.
- Cosmetic use only (for example, weight loss drugs not used to treat morbid obesity).
- Encourage use of therapeutically equivalent drugs when generics are available in the same drug classification. This is also known as targeted PA.

While less than 1 percent of covered drugs require PA, targeted PA has been shown to slow the rate of increase in drug expenditures without impeding access to necessary and appropriate drugs. Through PA, categories of drugs are reviewed for similar products, some of which are available generically and some only brand. When this situation exists, Wisconsin may recommend requiring PA for the brand drugs. However, before any changes are made to the PA requirements, drug manufacturers are notified and a review process, including manufacturer testimony, is followed. This process assures high quality to our recipients and cost-effectiveness for the program. The recently enacted budget reform legislation provides for an expanded PA Committee, to include practicing physicians and pharmacists from the state. The Department has already invited a number of practicing physicians and pharmacists from the state to participate. The Committee meets on an ad hoc basis. It met recently to consider requiring PA for proton pump inhibitor drugs and statin drugs.

The majority of drugs that require PA allow providers to submit PA requests electronically through the Wisconsin Specialized Transmission Approval Technology — Prior Authorization (STAT-PA) system. A response to this request for PA occurs almost immediately. The Wisconsin STAT-PA system may be accessed through a personal computer, touch-tone telephone, or help desk and is available 24 hours a day, 7 days a week.

PA is currently required for the following groups of drugs:

- Brand name non-steroidal anti-inflammatory drugs (NSAIDs [Cyclooxygenase-2 (COX-2) and Non-COX-2]).
- Angiotensin converting enzyme (ACE) inhibitors.
- C-III and C-IV stimulants.
- Anti-obesity drugs.
- Alpha-1 Proteinase inhibitor (Prolastin).

f) Diagnosis Restriction and Excluded Drugs. Under Wisconsin Medicaid, a diagnosis restriction applies if the prescribed use is not for a medically accepted indication. In addition, certain drugs may be excluded from coverage and are on the Medicaid

Negative Formulary drug list, including drugs that are less-than-effective as defined by the Food and Drug Administration (FDA), and drugs that are experimental.

g) Brand Medically Necessary. Wisconsin Medicaid does not automatically require PA for all brand name drugs. When a drug is available generically and is on our maximum allowed cost (MAC) list, SeniorCare will cover Brand Name Innovator drugs only when a brand medically necessary prescription is provided. Like Medicaid, the participant's prescribing physician must indicate "Brand Medically Necessary" in the prescriber's own handwriting on the face of each new prescription.

h) Maximum Daily Supply. Like Medicaid, the SeniorCare program will limit reimbursement for most drugs to no more than a 34-day supply. Certain maintenance drugs may be dispersed in a 100-day supply. This limitation discourages stockpiling of expensive drugs and reduces waste when drugs are discontinued. (Required co-payments of $15 per brand name drug and $5 per generic drug do not vary according to maximum daily supply limitations.)

Interaction Between State-only Program and Demonstration Program

The state-only funded pharmacy program and the demonstration program will have the same administrative and benefits management methodologies. However, SeniorCare participants in the state-only program will be identified separately from demonstration participants based on the participant's income. Although transparent to participants, the state will be able to identify which participants have income above 200% of the federal poverty level, and claims can be tracked separately for these individuals. Those participants that have income above 200% of the federal poverty level at the time their eligibility is determined will be included in the state-only program during the person's entire benefit period. The benefit period is either 12-months from the eligibility determination date, or the period of time from the eligibility determination date to the date the person re-applies and is determined eligible for a new benefit period. No participant will be able to "spend-down" into the demonstration program during his or her benefit period. A participant is determined to be either in the state-only program or the demonstration program based on the participant's income level at the time the person is determined eligible. This will ensure correct federal reporting for FFP match.

G. RELATED MEDICAL MANAGEMENT

Wisconsin has long been committed to ensuring that its residents have access to primary care services. This is evidenced through the extensive safety net of providers and the low rate of uninsured in the state. By coordinating and collaborating with the state's aging network, including the Coalition of Wisconsin Aging Groups (CWAG), the American Association of Retired Persons (AARP), the Association of Area Agencies on Aging, the Wisconsin Association of Benefit Specialists, and the Wisconsin Board on Aging and Long-Term Care, Wisconsin will ensure that persons interested in SeniorCare receive appropriate referrals to primary care services. Referrals may be provided to any

individual seeking information about SeniorCare, regardless of whether the person is enrolled in SeniorCare or is eligible for Medicare.

Wisconsin's Safety Net

Wisconsin has an extensive safety net of health care providers, with approximately 130 hospitals, 24 Federally Qualified Health Centers (FQHCs), which includes tribal health centers, 51 Rural Health Clinics, the Family Health Center of Marshfield which operates 13 health centers in rural Wisconsin, County General Assistance programs, and the Milwaukee County Medical Program.

The Uninsured in Wisconsin

Wisconsin continues to have one of the lowest rates of uninsured in the country. Based on 2000 Wisconsin Family Health Survey data, 6 percent of the state's residents are uninsured (measured at a point-in-time) and for those age 65 and over, 1 percent of Wisconsin residents are uninsured.

Collaboration with Aging Network

The Department will ensure coordination and referrals to primary care services through the aging network in the state.

- Wisconsin has established a SeniorCare Advisory Committee, including representatives from: CWAG, AARP, Wisconsin Citizen Action, Wisconsin Benefit Specialist Program, Area Agencies on Aging Association, and the Board on Aging and Long-Term Care. The Committee also includes representatives of pharmacies, pharmacists and pharmaceutical manufacturers, as well as a tribal representative and other community agencies.

  - The Advisory Committee provides input to the Department on important issues related to SeniorCare such as public information and education. The issue of coordinating primary care services and referring of SeniorCare participants to these services will be raised with members of the Advisory Committee. Each member will be provided a list of primary health care service providers to disseminate to the staff in their agencies who are working with SeniorCare applicants and participants.

- The Department has also been disseminating information and conducting training sessions with various organizations that will answer questions about SeniorCare, counsel seniors on the benefits of the program, and assist seniors in completing applications. The schedule began at the end of May, with a briefing to the Aging Directors from the Board on Aging and Long-Term Care. Training sessions have also occurred and/or are scheduled with benefit specialists, AARP volunteers, Care Managers from the Dane County Area Agency on Aging, and CWAG. Specialists who staff the MediGap Hotline have also attended SeniorCare trainings. Other presentations are scheduled with Senior Center Directors and Aging Unit and Nutrition Directors. Examples of how these organizations will assist us include:

- Benefit specialists are located in every county and tribe in Wisconsin. They assist persons age 60 and over with eligibility for all rights and benefits they may be entitled to receive, including MediGap policies. These specialists are a primary point of contact locally for seniors. The Department is considering pursuing federal matching funds for administrative costs associated with the SeniorCare program that have been incurred by local benefit specialists.

- AARP has a network of volunteers. AARP has planned events throughout the state, including van tours to promote the SeniorCare program and help eligible seniors enroll.

- In these training sessions, DHFS has provided materials and/or instruction, so that the staff and volunteers who are assisting and counseling seniors can make referrals to the appropriate safety net provider if a SeniorCare applicant or participant is having trouble accessing primary care services.

  - The Department will provide trainees with access to a listing of primary care providers, their locations, and phone numbers.

  - The Department will also provide other information, as determined necessary.

Information to Safety Net Providers

The Department is also providing information about SeniorCare directly to safety net providers:

- All safety net providers were sent a packet of marketing brochures for SeniorCare along with a cover letter introducing SeniorCare and explaining how they could obtain more information, additional brochures, and application forms.

- A detailed presentation about SeniorCare is currently scheduled for July 30, 2002, at the Marshfield Clinic.

Other Referral Mechanisms

- The Department has implemented a Customer Service Hotline for the SeniorCare program. Customer service staff have been provided materials, including access to a listing of safety net providers. Customer service staff have been trained to refer clients to the appropriate safety net provider if the customer indicates that he/she is having trouble accessing primary care services.

- The Department is developing a SeniorCare web page that will include information about the SeniorCare program, including application instructions and the application form. The SeniorCare web page will contain information about accessing primary care services, including:
  - A list (or a link to a list) of safety net providers.

- Links to safety net provider web pages (where available).

H. OUTREACH/MARKETING/EDUCATION

The outreach, training and education plan for SeniorCare has been developed and is being implemented by the DHFS. DHFS is the administering agency for eligibility determinations and benefits for the SeniorCare program (and for Medicaid). For SeniorCare, outreach, marketing and education is primarily the responsibility of the Department's Bureau of Health Care Eligibility (BHCE). BHCE coordinates with other Bureaus in the Department, including the Bureau of Aging and Long-Term Care (BALTCR). BALTCR provides an array of aging and long-term care resources. They work closely with the statewide benefit specialists and staff from the Area Aging Agencies, which assist seniors with application for various social service programs. BHCE, with assistance from BALTCR, have been training benefit specialists and staff from the Area Aging Agencies. Benefit specialists are primary points of contact for disseminating information and providing assistance in applying for SeniorCare at the local level.

In addition, the Department has established an Advisory Committee including representatives from the Coalition of Wisconsin Aging Groups (CWAG), AARP, Wisconsin Citizen Action, Wisconsin Benefit Specialist Program, Area Agencies on Aging Association, and the Board on Aging and Long-Term Care. The Committee also includes representatives of pharmacies, pharmacists and pharmaceutical manufacturers, as well as a tribal representative and other community agencies. Advisory Committee members have reviewed and provided input on the SeniorCare application and instructions, marketing brochure, presentation slides, and other public information.

Due to the volume of calls already received by the Department in anticipation of the SeniorCare program, we believe that the public is generally aware that SeniorCare will provide prescription drug benefits to Wisconsin seniors. However, additional details about the program are needed for seniors and for those assisting seniors. Our goal is to allow all seniors to make an informed choice about applying for benefits. The outreach plan has four major components: training of benefit specialists and others who will counsel and assist seniors in applying for the program; training of providers; educational materials; and media outreach. Each of these is described in more detail throughout the remainder of this section of the Operational Protocol.

Information for Enrollees, Participating Providers, and State Staff

The SeniorCare application form, application instructions, general fact sheet, marketing brochure, and television ad script were sent to CMS on June 4, 2002. These materials have been distributed to the public. In addition, the Participant Handbook was sent to CMS on July 11, 2002. The Participant Handbook (Attachment 16) will be sent to participants upon eligibility determination. Additional details about SeniorCare information for enrollees, providers and staff are provided below.

Applicants and Enrollees. First, the Department has been working on a series of fact sheets that will provide detailed information about complex policies of the program. A general fact sheet has been provided on the web site since early this year. Other fact sheets describing income determination for married couples, and other issues are being developed. Additional fact sheets will be developed, as determined by the Department.

In addition, the Department has developed a marketing brochure to be disseminated as described below. The marketing brochure provides the SeniorCare logo, general information about the program, including cost-sharing requirements and where more information can be obtained. The Department is also working to develop a poster and tabletop displays that will provide information about the program.

The Department has also developed a Pre-Application Guide, which is a web-based interactive tool that will allow seniors or their families or others helping them determine what benefits they would qualify for if they applied for SeniorCare. This tool will be available on the SeniorCare web site. There is no charge to anyone to use this tool.

Once enrolled in the program, all SeniorCare participants will receive a Participant Handbook that will explain SeniorCare policies in detail. Again, the person will be provided with information about where to call for more information about SeniorCare and for information about other benefit programs such as Medicaid.

Finally, information will be communicated directly to seniors through the toll free SeniorCare Customer Service Hotline, through local contacts with benefit specialists, or through contact with other organizations. For example, AARP, an organization with representation on our Advisory Committee, has planned a series of events throughout the state to assist seniors in applying for SeniorCare. AARP representatives have been trained by the Department to provide assistance.

SeniorCare will make available bilingual materials/interpretation services and services for individuals with special needs, and will inform applicants and participants of cost-sharing responsibilities.

The SeniorCare Customer Service Hotline includes Spanish, Hmong and Russian greetings that will explain what the person should do if they need interpretation services over the phone. The hotline will use AT&T translation services for individuals who need interpretation services. TTY services are also available when using the hotline.

The SeniorCare application instructions are being translated into Spanish, Hmong, and Russian as will other informing materials such as the marketing brochure, fact sheets, and the Participant Handbook. The translation of the application instructions is expected to be completed in mid-September. The translation of the other materials is expected to be completed by the end of September. The application and instructions will also be available in Braille or large print upon request. This option is currently available. Customer service staff forward the request to the Department, and the request is then processed using a machine that is located at the Department.

Through the SeniorCare Customer Service Hotline, the marketing brochure, fact sheets and the Participant Handbook, applicants and participants will be informed about the cost-sharing responsibilities under SeniorCare.

Participating Providers. Participating providers were given information about the program through two training sessions in August 2002. Providers will be trained to answer questions, particularly about program benefits, the deductibles and co-payments. Providers will be given posters, tabletop displays, applications and other marketing materials as desired.

State Staff. The Department has recruited individuals to assist seniors in filling out applications in a number of ways.

- First, benefit specialists have long-term experience assisting seniors in Wisconsin and have ongoing relationships with seniors, senior centers, and organizations that assist the elderly. Benefit specialists have been recruited to assist us through a partnership between BHCE and BALTCR. BALTCR works closely with the statewide benefit specialists and staff from the Area Aging Agencies. Through the partnership between BHCE and BALTCR, benefit specialists are primary points of contact for disseminating information and providing assistance in applying for SeniorCare at the local level.
- Second, the training events shown in the table later in this section of the Operational Protocol, were an important means of recruiting volunteers. We worked with staff at the Aging Units and senior centers to inform local volunteers of these training events.
    - As a result of attending one of the Department's training events, several attendees in turn recruited additional staff and volunteers to assist seniors. They provide information through separate training sessions to these staff and volunteers at the local level.
- Third, DHFS has coordinated and collaborated with the state's aging network, including the Coalition of Wisconsin Aging Groups (CWAG), the American Association of Retired Persons (AARP), the Association of Area Agencies on Aging, the Wisconsin Association of Benefit Specialists, and the Wisconsin Board on Aging and Long-Term Care.
    - At least one of these organizations, AARP, has planned a series of events throughout the state to assist seniors in applying for SeniorCare.

Seniors are informed of assistance through the benefit specialists and AARP in a number of ways. First, each county/tribal aging unit has established their own local service delivery network. Through this network, seniors are informed about how they can apply for SeniorCare. Seniors may find a list of the aging units on the SeniorCare website. Second, the SeniorCare Customer Service Hotline number has been made available to seniors on the application instructions, on the SeniorCare brochure, and through TV advertising. The hotline number will also be on posters, included in a radio advertisement, and has been provided to pharmacists who serve seniors. Seniors who call the customer service hotline may be referred for assistance to benefit specialists or may be informed of AARP enrollment events. Finally, AARP conducted extensive

advertising in newspapers throughout the state to inform seniors of their SeniorCare enrollment events. These events have resulted in 702 trained volunteers serving over 8,700 seniors, according to AARP's records. In order to draw additional attention to SeniorCare enrollment, the Governor attended the first day of the AARP enrollment tour in Milwaukee and also attended other SeniorCare-related events in Green Bay, Milwaukee, and Wausau. The Lieutenant Governor attended a senior center event in LaCrosse.

DHFS staff has conducted outreach and educational activities for individuals who assist seniors in filling out applications, who may have contact with seniors, and who may be involved in answering questions or need to understand the basic elements of the SeniorCare program. Because audiences will vary, there are two types of presentations we are conducting - general program descriptions and more detailed trainings. Agencies in the Aging Network may provide additional training for their staffs.

State outreach activities will inform individuals of their potential eligibility for non-demonstration Medicaid, Medicare Premium Assistance, and other programs. As noted throughout the presentation materials provided, many of the policies for SeniorCare are very similar to non-demonstration Medicaid policy. This provides us with the opportunity to remind trainees about Medicaid, including the Medicare Premium Assistance programs. Many of the groups in our trainings have detailed knowledge about Medicaid, which allows for detailed discussion about both programs. In addition, the benefit specialists, who we view as primary local contacts for seniors, have long-term experience helping elderly persons apply for and understand benefits of a broad array of public programs including Medicaid and the Medicare Premium Assistance programs.

In addition to opportunities to discuss Medicaid at presentations and trainings, participant materials will include information about Medicaid. Beginning with the implementation of SeniorCare, the automated eligibility system, CARES, will generate a notice that includes a reminder to eligible SeniorCare applicants with income below 135 percent that they could be eligible for assistance with their Medicare premiums. The notice will refer them to the nearest local county department of human/social services to apply. If they apply, they will be automatically screened for non-demonstration Medicaid benefits. In addition, eligible SeniorCare participants will receive a Participant Handbook that will provide them with detailed information about their rights and responsibilities under SeniorCare, and will also indicate how to obtain more information about other public benefits programs such as Medicaid.

Finally, as mandated by federal legislation (the Beneficiary Improvement and Protection Act, passed on December 21, 2001), the Social Security Administration (SSA) is sending out letters to more than 15 million people nationally who may be eligible for the Medicare Premium Assistance. These include Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals 1 (QI-1). The legislation requires SSA:

- To use its records to identify potential Medicare Savings Programs candidates;

- To implement annual MPA programs outreach notification to identified beneficiaries by December 21, 2002 (one year from enactment); and

- To at least annually share information with States on potential MPA Programs beneficiaries.

The SSA is in the process of sending out an estimated 15 to18 million letters at a rate of 100,000 a day for 6 months. The mailings will be done randomly on a nationwide basis to evenly distribute the workload. SSA has informed Wisconsin that state residents will receive 344,293 letters over the next six months, beginning May 10, 2002.

Types of Media Used for SeniorCare

SeniorCare will use a wide variety of media to ensure equitable access to information for seniors across the state. Marketing materials include all of the following:

- A marketing brochure;
- Television ad, which began airing June 25, 2002, in markets throughout Wisconsin;
- Radio announcement scheduled for September;
- Posters; and
- Tabletop displays for pharmacies.

The Department is also examining the feasibility of newspaper ads.

In addition, we have supported activities of our partners in the aging network in writing newsletters and other activities such as the AARP "van tours."

Target Geographical Areas and Locations where Information will be Disseminated

Outreach activities will occur statewide**.**

Marketing brochure to be distributed to:

- County and tribal aging units according the percent of their population that is over 65;
- Pharmacies throughout the state;
- Safety net providers (hospitals, FQHCs, rural health clinics);
- The Central Application Processing Operation (CAPO) for distribution to individuals who call the customer service hotline; and
- Other sites available upon request.

TV Ad. To be distributed statewide through a leveraged media buy, in addition to public service announcements.

Posters. To be distributed to aging units, economic support agencies, pharmacies other health care providers, and also available upon request.

Tabletop displays. Primary distribution to pharmacies.

Staff Training Schedules and Seminars

Date/Location	Group (Number of Participants)
April 5, 2002 – Wis. Dells	Association of National Eligibility Workers, (95)
May 29, 2002 – Madison	County Aging Directors, (25-30)
June 10, 2002 – Madison	DHFS Staff not involved in SeniorCare (30)
June 11, 2002 – Madison	Conference call with Tribal Health Directors and Tribal Pharmacy Representatives
June 13, 2002 – Manitowoc	Wisconsin Social Services Association (75-80)
June 18, 2002 – Madison	Benefit Specialist Attorneys, Medigap Hotline Staff, Coalition on Wisconsin Aging Staff, (20-25)
June 19, 2002 – Madison	Training for AARP Staff/Representatives, (160)
June 21, 2002 – Wausau	Benefit Specialists Training, (75-80)
June 24, 2002 – Madison	Division of Administrative Hearings, (15)
June 25, 2002 – Milwaukee	Milwaukee Network Training, (120)
June 27, 2002 – Madison	Training for Dane Co. Area on Aging Care Managers (40-50)
July 1, 2002 – Milwaukee	BadgerCare Coordination and Care Network, (50)
July 10, 2002 - Eau Claire	Coalition on Wisconsin Aging Groups Training, (30-50 participants, 2 sessions)
July 30, 2002 – Marshfield	Marshfield Clinic, (130 participants, 2 sessions)
August 8 and 14 – Madison (ETN)	Pharmacy Provider Trainings (Number participants TBD)
Ongoing Fall Presentations (dates and locations TBD)	Senior Center Directors, Coalition on Wisconsin Aging Groups, Additional Benefit Specialist Presentations

Consumer Protection

The Department will include a consumer protection component to outreach activities. The state will work to prohibit anyone from taking advantage of the elderly population by using the SeniorCare name. A SeniorCare logo and tag line have been developed and is now a registered trademark. The logo is included on all of our marketing materials, including the brochure and TV ad, the SeniorCare application form and instructions, the Participant Handbook, eligibility notices, and the web site. In addition, we have been informing the public, through training sessions, of the need to be aware of these issues. Newspaper articles about the SeniorCare program have also included information about consumer protection.

I. ELIGIBILITY/ENROLLMENT

To be eligible for prescription drug services under this demonstration program, individuals must:

- Be a Wisconsin resident;
- Not be a recipient of Medicaid other than as a low-income Medicare beneficiary;
- Be age 65 or older; and
- Pay the applicable annual enrollment fee of $20 per person.
- As with Medicaid, SeniorCare eligibility also requires that the person be a U.S. citizen or a qualifying alien.

Individuals must also have a household income at or below 200 percent of the FPL. Individuals with a household income above 200 percent of the FPL may be eligible for the state-funded SeniorCare program. Income will be calculated as follows:

- A gross income test will be used, except in cases of self-employment income. The standard elderly, blind and disabled (EBD) Medicaid deductions, and other deductions, disregards, exclusions and exemptions will not be applied to SeniorCare participants as they are to non-demonstration Medicaid.
- In cases of self-employment income, current Medicaid policy for elderly, blind and disabled programs will be followed. Therefore, deductions for business expenses, losses and depreciation will be permitted for persons with self-employment income.
- Income will be determined annually, on a prospective basis.
- A fiscal test group that is consistent with current Medicaid policy for the elderly, blind and disabled program will be used. Thus, the income of the individual will be used for persons not living with a spouse, and the income of the couple will be used for married persons who reside with their spouse. These income amounts will be compared to the FPL for a group size: One, if counting only the income of the individual; and two, if counting the income of the applicant and his or her spouse.

- There will be no asset test related to eligibility for the SeniorCare waiver program.
- There are currently no plans for estate recovery under the demonstration.

Eligibility Determination Process

Based on the experience of other states, it is anticipated that 70 percent of the estimated number of SeniorCare participants will apply for SeniorCare within the first three months of the program. We have hired staff on a limited-term basis to assist in processing the large volume of applications expected from July through October.

Application processing and eligibility determinations will be conducted at the central application processing operation (CAPO) located in Madison, Wisconsin, and under the direct supervision of the single state Medicaid agency. The primary functions of CAPO staff will be customer service and application processing, including eligibility determination. CAPO staff will consist of both public (state) employees and private sector employees hired by the Department's fiscal agent, EDS.

The following activities will be performed by public workers:

- Initiation of eligibility determinations in CARES, the state's automated eligibility determination system for SeniorCare and Medicaid;
- Review of eligibility determination results;
- Performance of required queries/data exchanges of online information to verify applicant information;
- Confirmation of eligibility in CARES; and
- Transmission of CARES data to MMIS, the claims processing system for SeniorCare and Medicaid.

Public workers will also perform post-confirmation tasks associated with, at a minimum, re-determinations of eligibility, change reporting, quality assurance reviews/data exchange, fair hearings and recovery of benefits.

For purposes of ensuring the integrity of the program, the quality of the information recorded, and excellent customer service, SeniorCare staff and local agency staff will have access to the same information about clients who are enrolled both in SeniorCare and in other economic support programs, such as food stamps.

Wisconsin will use the same automated system (CARES) to support eligibility determinations for SeniorCare as is used by local agency staff for other programs. Although the eligibility processes for SeniorCare are distinct from other economic support programs, state and county level workers will have the ability to share information. For example, if a client provides a new address or if income information appears to be significantly different from information currently in the system, the SeniorCare eligibility staff will work to resolve the discrepancy with the local agency.

Annual Redetermination Process

The Department is currently planning to send a pre-printed review form to all participants during their 10th month of eligibility. The participant will have to review the form, make any appropriate modifications to the information provided, and mail the form along with the annual $20 enrollment fee to the SeniorCare Central Application Processing Operation, or CAPO.

Intake, Enrollment, and Disenrollment

Intake and Enrollment. Applications will be mailed to the Central Application Processing Operation in Madison. As noted above, CAPO staff will process applications and determine eligibility. All applicants will receive a notice of eligibility.

Maintaining the Benefit Period. Once enrolled, the Wisconsin statutes require that each SeniorCare participant receives a 12-month benefit period, and a participant's cost-sharing is based on the income determined at the time of application (the beginning of the 12-month benefit period).

Under statutory provisions, any change in income – an increase or decrease – is not required to be reported and does not result in a change in the person's 12-month period. Thus, a participant is allowed to maintain his or her original eligibility determination throughout the entire 12-month period, even if income increased during that time.

The benefit period is also maintained for SeniorCare participants who become recipients of non-demonstration Medicaid. The SeniorCare statutes specify that a person eligible for SeniorCare may not receive regular non-demonstration Medicaid. However, SeniorCare will remain open for participants in the waiver demonstration project who, during their 12-month benefit period, become eligible for full Medicaid benefits. In these situations SeniorCare will not cover the person's drug costs, but if the person subsequently becomes ineligible for full Medicaid benefits during the 12 months, they will automatically be able to receive SeniorCare benefits again without having to re-apply or pay another $20 fee.

Establishing a New Benefit Period. A SeniorCare participant may elect to establish a new 12-month benefit period if the participant has a decrease in income that would change his/her status in SeniorCare so as to reduce his/her out-of-pocket expense or cost-sharing requirement. The SeniorCare statutes require that for each 12-month benefit period a person must meet all eligibility requirements, including payment of the $20 enrollment fee.

We are able to assist a person in determining if it would be beneficial to exercise the option to establish a new 12-month benefit period.

- First, the person could receive assistance from the senior network supporting the program or from the SeniorCare customer service hotline. In either instance, staff are trained to counsel participants about all issues related to SeniorCare eligibility and

cost-sharing requirements, including whether it would be beneficial to the person to elect a new 12-month benefit period.

- Second, the Department has developed a new interactive web-based pre-screening tool (the pre-application guide) that will assist persons in making well-informed decisions about whether to apply for the SeniorCare program or to re-establish their 12-month benefit period. This guide is currently available on our website at www.dhfs.state.wi.us/seniorcare/index.htm. Using the guide, a person answers a series of questions about his/her age, residency, household composition and income. Based on the information entered by the person, the pre-application guide will calculate annual income for the person, indicate if the person might be eligible for SeniorCare and indicate what the person's cost-sharing requirements might be.

Disenrollment. The SeniorCare statutes require that a person be a Wisconsin resident to participate in SeniorCare. Thus, if a person moves out of state, that person is no longer eligible for SeniorCare and will be disenrolled. A person who dies will also be removed from the SeniorCare eligibility files.

The SeniorCare statutes also specify that a person eligible for SeniorCare may not receive regular Medicaid. SeniorCare will remain open for participants in the waiver demonstration project who, during their 12-month benefit period, become eligible for full Medicaid benefits. In these situations SeniorCare will not cover the person's drug costs, but if the person subsequently becomes ineligible for full Medicaid benefits during the 12 months, they will automatically be able to receive SeniorCare benefits again without have to re-apply or pay another $20 fee.

Finally, SeniorCare participants may voluntarily choose to opt out of SeniorCare at any time. Participants may opt out in writing or over the phone by calling SeniorCare Customer Service. The person will be disenrolled as of the date the phone call or written letter is received. If a person chooses to opt out within 30 days of the date their application was received by the Central Application Processing Operation, or 10 days from their eligibility notice date, whichever is later, the $20 enrollment fee will be refunded.

Enrollment

Wisconsin statutes require that, during any period in which funding for benefit payments under the program is completely expended, all of the following shall apply:

- The Department may not pay pharmacies or pharmacists for prescription drugs sold to program participants;
- Pharmacies and pharmacists will not be required to sell drugs to eligible program participants at the program payment rate;
- Eligible program participants will not be entitled to obtain prescription drugs for the co-payment amounts or at the program payment rate;

- The Department may not collect rebates from manufacturers for prescription drugs purchased by program participants; and

- The Department is required to continue to accept applications and determine eligibility for the program, and must indicate to applicants that the eligibility of program participants to purchase prescription drugs under the requirements of program is conditioned on the availability of funding.

These provisions would potentially be utilized if state funding budgeted for program benefits were insufficient to meet program needs. The Department will closely monitor SeniorCare enrollment and expenditures and if, at any time, projections indicate that funding is not sufficient to continue paying benefits, the Administration will notify the Legislature. We expect to know months in advance if this were to happen, which would allow adequate time for the Legislature to act. Moreover, state funding for SeniorCare is budgeted in a biennial appropriation, which provides greater flexibility in the expenditure of budgeted funds over the two-year budget period.

Coordination with Medicaid Eligibility and Enrollment Processes

Existing systems that support the Medicaid program will be used for automated support for eligibility and enrollment functions. The state will leverage existing system capacity to meet the program needs in the most efficient way, and to assure coordinated implementation of SeniorCare as a Medicaid benefit program. A comparable result was successfully achieved for low-income families with children in the state's Titles XIX and XXI demonstration waivers for BadgerCare, which provided seamless coordination with Medicaid, including elimination of the welfare stigma of Medicaid-funded services through program design, public information, and cost-sharing.

SeniorCare will use the state Medicaid program's Point-of-Sale (POS) system for claims processing. The POS system has in place the mechanisms for drug pricing, calculation of co-payments and deductibles, providing enhanced pharmaceutical care services, STAT prior authorization, prospective and retrospective Drug Utilization Review (DUR), and other cost containment processes. The system enables Medicaid-certified providers to submit real-time claims electronically for prescription drugs and to receive an electronic response indicating payment or denial within seconds of submitting the claim. The system also verifies recipient eligibility, including other health insurance coverage, and will track participants' deductibles and co-payments against information available to pharmacists in real-time. As a result, seniors filling their prescriptions may receive up-to-date information about their prescription costs.

Similar to Medicaid, SeniorCare must coordinate eligibility across programs and coordinate with benefits covered by other insurers. Many seniors who are eligible for SeniorCare will also be eligible for programs such as food stamps or other economic support programs. A SeniorCare Customer Service Hotline is currently operational with staff responding to questions about eligibility, applications, and program benefits. SeniorCare application processing staff have been trained to answer questions and provide referrals for seniors seeking information about SeniorCare or other programs.

Persons who call the SeniorCare Customer Service Hotline may be referred to the State's Medigap hotline for issues about coordinating SeniorCare and Medigap policies. Further, Medigap hotline staff attended our SC training on June 18th. Potential SC participants who call the Medigap hotline may receive information about coordination between Medigap and SeniorCare. Finally, benefit specialists who assist seniors in applying for SeniorCare have extensive knowledge and experience in helping seniors with public programs and understanding how those programs work with private coverage. Thus, seniors may also receive information about the coordination between Medigap and SeniorCare from the benefit specialists.

J. QUALITY

Monitoring of Operations

Using the existing eligibility determination system, CARES, and the Medicaid Management Information System we plan to leverage and enhance existing system functions and processes that monitor quality and detect errors or potential problems. Also, similar to Medicaid, data from these systems on eligibility, claims and providers will be stored in the Medicaid data warehouse and decision support system called MEDS system(Medicaid Evaluation and Decision Support). This system will provide instant easy access to this SeniorCare program data to monitor quality**.**

Monitoring Application Information. Program staff conduct random samples of applications that have been submitted to the SeniorCare program for purposes of monitoring the scanning of applications, the data entry into the CARES system, and the quality of data submitted by applicants.

- Applications are both scanned and validated through a double-indexing process that utilization optical character recognition software and manual review. We are using a standard of a 95% confidence level for optical character recognition.

- Through a variety of monitoring mechanisms, the scanning operation is achieving a 97% accuracy rate.

- Through a statistically valid random sample of data from the scanner, we are monitoring both scanning and applicant errors. Through this monitoring, we are able to further improve accuracy in eligibility determinations.

Eligibility Determination System. It is anticipated that certain income sources may have limited applicability for the waiver demonstration population, which generally is perceived as having fixed income. Further, because income is tested prospectively on an annual basis under the waiver demonstration and because data from other sources represents a prior time period, some items may not be relevant in determining eligibility for SeniorCare. In exploring the most efficient and effective methods for ensuring program integrity, Wisconsin intends to do the following:

- Validate social security numbers at the time of application through the Social Security Administration numident process. If it is found that a person does not have a social

security number, the person will be assisted in obtaining a social security number. If it is found that there is a mismatch between the SSA information and the social security number provided by the client, the mismatch will be resolved as needed.

- Automatically test Social Security Administration benefits against tolerance levels established by the Department at application and review. Those case situations that exceed tolerance levels will be verified and discrepancies will be resolved. In addition, periodic random samples of all cases will be conducted to ensure that SeniorCare eligibility is based upon the correct social security benefit information regardless of whether there is a discrepancy that exceeds the threshold.
- In addition, social security administration benefits, earnings from wages, earnings from self-employment, other unearned income and unemployment compensation will be verified after application to ensure program integrity. In particular, a random sample of all recipients will be taken. If a misstatement, omission of fact or failure to report information results in an incorrect eligibility determination, program costs would be recovered.

MMIS and MEDS. The State will monitor the operation and quality of services delivered under this demonstration through a combination of data analysis, utilization review, and customer satisfaction. In addition, The Bureau of Health Care Program Integrity will perform exception analysis reports that will trigger situations that may warrant further investigation.

Identification of Issues Needing Attention

There are several ways in which the State will be alerted to issues that need attention. In addition to data analysis and utilization review, DHFS will rely on information received from the toll-free SeniorCare Customer Service Hotline to monitor the operation of the program and the services received. Calls from seniors will be tracked and problems encountered will be referred to the program manager for follow-up and resolution. A network of community-based providers will be trained to report concerns to DHFS to provide a central clearinghouse for all matters pertaining to SeniorCare.

Quality Indicators, Feedback and Monitoring Plans

The SeniorCare program is expected to improve the health of the participating elderly population. Wisconsin will use a combination of measures and strategies to monitor the health of participants in the SeniorCare program, which are discussed in detail in the evaluation section of this document.

However, in general these measures and strategies include using: 1) The Wisconsin Family Health Survey to measure the levels of self-reported health; 2) Medicare and Medicaid data to measure health services utilization rates associated with acute and chronic diseases particularly amenable to treatment with medication; and 3) The Drug Utilization Review (DUR) system to provide both a prospective and retrospective review of prescription claims. Below are descriptions of these programs.

Prospective Drug Utilization Review (DUR). The Medicaid prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important drug therapy problems before the prescription is dispensed to the recipient. This screening is done electronically in real-time using Wisconsin Medicaid's point-of-sale system. The system uses alerts or screens for therapeutic duplication, drug/drug interactions, early and late refills, cumulative side effects, and drug contraindications for pregnancy, certain diseases, and specific ages.

Pharmacists are required to respond to all alerts before a drug claim will be paid. The pharmacist must indicate the action taken to address the potential drug problem and the outcome of the action. All prospective DUR alerts are recorded and put into the data warehouse. Reports are prepared indicating the percent of alerts by individual pharmacy as well as the pharmacists' responses to all alerts. These reports are used to monitor how pharmacists address these potential drug problems and to identify alerts that should potentially be removed. For example, if an alert for a particular drug combination is continually being overridden, the DUR pharmacist will review this for clinical significance. It may be appropriate to remove that drug combination or to contact the pharmacist or prescribing physician for an explanation.

Retrospective DUR. The Medicaid retrospective DUR program provides for the ongoing periodic examination of paid claims data and other records in order to identify possible patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care associated with specific drugs or groups of drugs. Retrospective DUR will provide seniors with information that can improve drug utilization through provider and patient education.

Retrospective DUR interventions provide patient specific information directly to prescribers. This intervention includes a letter describing the potential drug problem, a complete patient drug history for the past year, and a response form. The response form requests the physician to inform us about how the problem identified has been addressed and also provides the prescriber an opportunity to rate the usefulness of the information. Previous experience in the Medicaid program results in a 66% response rate and 75% of responders indicate that the information provided is useful or very useful.

Responses received from retrospective and prospective DUR as well as the types and volumes of alerts and interventions are used to identify issues for further program development. Changes in prescribing patterns and the availability of less costly drugs may also result in an educational effort. The feedback from the DUR program is addressed in a number of ways, the three largest being pharmaceutical care, educational newsletters, and targeted interventions.

- Pharmaceutical Care (PC). Wisconsin Medicaid leads the nation in this innovative program which promotes a patient-centered outcomes-oriented practice of pharmacy. Its purpose is to maximize the effectiveness of medications for the patient through intervention by the pharmacist. Wisconsin's PC program provides pharmacists with an enhanced dispensing fee for PC services given to Medicaid fee-for-service

recipients. This enhanced fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug. Pharmacies may receive an enhanced PC dispensing fee only when their service increases patient compliance or prevents potential adverse drug problems and results in a positive outcome for the Medicaid Program.

A prospective DUR alert may identify a potential drug problem requiring additional intervention by the pharmacist. When appropriate, and if the pharmacist meets all the necessary requirements, the pharmacist may bill for and receive an enhanced dispensing fee for pharmaceutical care.

Pharmacists bill for PC by completing the DUR fields on the drug claim form. These fields indicate the reason for the PC, the action taken and the outcome. The pharmacist also fills in the level of service to indicate the time spent providing the PC. PC has annual limits on the number of times pharmacists may bill any particular code as well as limits on the level of service allowed.

- Educational Newsletters. The Division of Health Care Financing uses DUR program data to educate prescribers and dispensers on common drug therapy problems with the aim of improving patient care. The POS system permits timely use of prescribing data to improve system function.

  Feedback from the DUR programs, from prescribers, or from reviews of current medical literature as well as changes in the drug market may point out the need for additional information for prescribers and dispensers of drugs. Educational newsletters are developed to address these issues. Using the database, newsletters are targeted to the most appropriate audience for the newsletters. For example, a newsletter about the appropriate use of nonsteroidal anti-inflammatory drugs (NSAIDs) was sent to any prescriber who had 5 or more patients for whom he had prescribed an NSAID in the past 6 months. Topics addressed in the Medicaid program have included NSAIDs, antidepressant use, treatment of chronic pain, common drug/drug interaction for antidepressants, and the use of ACE inhibitors. Copies of the Newsletters are included in Attachment 15.

- Targeted Intervention. Information from current literature, review of drugs claims, and responses to DUR interventions are used to identify specific patients that may benefit from a more targeted drug intervention. Wisconsin Medicaid targets interventions for patients with specific diseases in a comprehensive and coordinated manner by working directly with local providers. Two examples follow:

  - *Asthma*

    - The Wisconsin Medicaid DUR Program identifies recipients who have frequent hospital use for asthmatic complications and do not receive appropriate drug therapy.

      Prescribers and pharmacists are alerted to their patient's drug use problems and potential therapeutic responses.

- In a special study, Wisconsin Medicaid reviewed 925 patients with asthma who had certain targeted criteria for emergency room or hospitalization use. Intervention and educational letters on behalf of 137 patients were sent to prescribers and pharmacists. The study showed that over a six month period, expenditures for drugs for these patients increased by $6,500, emergency room expenditures decreased by $7,300 and overall hospitalization expenditures decreased by $77,000.

- Prospective DUR alerts identify for pharmacists excessive use of drugs prescribed to treat asthma symptoms, providing an opportunity for pharmacists to discuss with the recipient or prescriber the need for alternative treatment.

- We conduct annual physician and pharmacist education on asthma management.

- We coordinate the criteria used to identify high risk patients under our fee-for-service and managed care programs.

- *Diabetes*

  - The Diabetes Advisory Group, a partnership of the state, health insurers, providers, purchasers, professional organizations and academia, have developed guidelines for diabetic care in an effort to provide standards for basic preventive services. Most HMOs in the state readily adopted these standards and are working on measures of diabetes care including eye exams, glucose tests, lipid management, kidney function and special immunizations. A patient version of these standards has also been developed to encourage personal proactive care.

  - In addition, our drug utilization review program is able to monitor diabetic drug use. Quality monitoring surveys are conducted, with quarterly reports provided to each HMO for specific recipients who have not received recommended services. Fee-for-service data is monitored on an annual basis for recommended service delivery.

A copy of the Wisconsin Medicaid Pharmacy Handbook chapter about DUR and Pharmaceutical Care which provides more detailed information about these programs is included in Attachment 17. Attachment 18 is a CD version of the complete Wisconsin Medicaid Pharmacy Handbook.

The Nursing Home Drug Profile. Quality measures are provided to each nursing home. The report includes the nursing home's pattern of drug therapy compared with other homes with similar populations. These peer group comparisons provide a context for administrators and health professionals to assess their pharmacy use practices. Facility reports are used to educate nursing staff about potential inappropriate drug use practices of classes of drugs in their nursing home. Trending reports will permit DHCF to monitor

changes in drug use practices within each nursing home. A sample of such a report is included in Attachment 19.

Fraud Control Provisions

DHCF will utilize many of the same fraud control provisions and monitoring for SeniorCare that exist for Wisconsin Medicaid. Any reports of fraud will be immediately reported to the Medicaid Fraud Control Unit at the Wisconsin Department of Justice. In addition, consumer alerts have been issued and DHFS will work with the State Insurance Commissioner and Consumer Protection agencies as necessary to ensure participants are receiving accurate information. Other safeguards such as a data cross match between death records and SeniorCare eligibility files and paid claims data will be conducted, and exception analysis reports will be performed that will trigger situations warranting further investigation. Lastly, follow-up interviews or surveys will be conducted to ensure proper participant payments while in the deductible phase of the SeniorCare program.

Monitoring of Overall Health Measures

Please see Section L - Health Improvement Evaluation Plan - for information that will be collected to coordinate and monitor pharmacy services as they relate to overall health measures.

K. GRIEVANCES AND APPEALS

All of the grievances and appeals policies are the same as non-demonstration Medicaid, with two exceptions:

1. Required notification by the Department prior to an adverse action in cases where the recipient has clearly indicated that he or she no longer wishes to receive services. The 10-day required notification prior to an adverse action does not apply in cases where the recipient has clearly indicated in writing that he or she no longer wishes to receive services. Under the waiver demonstration, an exception to the 10-day required notification will also apply in cases where the recipient has clearly notified the Department, verbally, that he or she no longer wishes to receive services.
2. Location where a person must send a request for an appeal. All requests for appeals must be submitted directly to the Division of Hearings and Appeals in the Department of Administration. The Division of Hearings and Appeals currently handles all Medicaid-related appeals, but currently a Medicaid recipient may file an appeal with the local agency.

L. EVALUATION DESIGN

Through SeniorCare, many thousands of Wisconsin seniors will have improved access to prescription drugs, widely recognized as a basic and cost-beneficial primary care benefit. This is expected to result in a healthier population and a delay or avoidance of eventual enrollment in Medicaid. The delay or "diversion" from Medicaid is expected to occur as a result of both clinical and financial outcomes. Clinically, the health of many seniors is expected to improve, or the onset of illness will be delayed. Financially, it is likely that

fewer seniors will be forced to "spend down" to Medicaid eligibility. As a result, it is expected that the overall impact on expenditures for Medicaid services for the elderly will be no higher than what would have occurred in the absence of SeniorCare.

The evaluation plan calls for outcomes to be measured in three key areas. First, access to the benefit will be measured. Second, budget neutrality will be demonstrated. Finally, the health of Wisconsin seniors will be monitored. The following describes the evaluation design including the key hypotheses, outcome measures, data selection and gathering, the strategies for isolating the effect of the program (where applicable) and other relevant evaluation information.

The following provides a statement of each evaluation hypothesis, the outcome measure of interest, the data that will be used to measure the outcome and, where applicable, a strategy for dealing with the problem of isolating the effect of the demonstration.

Hypotheses, Outcome Measures, Data and Isolation of Effect - Access

Access Hypothesis**.** *The pharmacy benefit will improve access to prescription drugs for the participating elderly population.*

The program population consists of residents of Wisconsin aged 65 and older. Currently, access to prescription drugs for this population is uneven and depends on many factors including prior work history, income and the degree to which individual policies offer comprehensive and low out-of-pocket access to benefits. The availability of a statewide direct benefit program with broad prescription benefits, modest cost-sharing and few benefit restrictions is expected to improve access to prescription drugs for this population.

Access Outcomes. *The outcome measures and their relationship to access are:*

- *Access to Coverage*: A comparison of the estimated number and percentage of Wisconsin residents aged 65 and older that have prescription drug insurance before SeniorCare was available and after the benefit became available.

- *Breadth of Coverage*: The level of coverage of prescription drugs including product restrictions and cost-sharing for plans that were available to seniors prior to SeniorCare, compared to SeniorCare.

Access Data. *The data that will be used to evaluate this hypothesis is as follows:*

- *Access to Coverage:* Two data sources will be obtained to assist in determining the degree of access to prescription drug insurance at baseline and over the life of the demonstration.

- The 2002 Wisconsin Family Health Survey (described in more detail below) has added five questions relating to prescription drugs for seniors. These include direct questions on whether or not individuals have prescription drug insurance, and

whether or not they have had to forego other basic necessities or purchase less medicine than was prescribed because of cost considerations. The new survey questions will establish a baseline near the time when SeniorCare is first available. While the results are issued annually, the instrument is actually administered quarterly so there should be ample opportunity to measure variations over time.

- A literature review will be conducted and estimates will be gathered and used to augment the information above. The review will focus on estimates of insurance coverage for prescription drugs for seniors nationally, regionally and, if available, by state. It will be conducted at annual or more frequent intervals throughout the demonstration in order to ensure that newly reported results are not missed.

- *Breadth of Coverage:* For those seniors who do have other insurance, a sample of the most frequently utilized of these private insurance plans will be assessed for their coverage details and comprehensiveness through a telephone survey of insurance companies. This will include separate considerations of premium rates, deductibles, co-payment rates, coinsurance rates and any benefit limits, product restrictions or other limitations. This will form the basis of a comparison between the private market plans and SeniorCare in terms of benefit generosity, coverage restrictions and out-of-pocket costs. This information will come from the coordination of benefits insurance coverage tapes that are maintained and used by DHCF to ensure third party liabilities are collected.

Isolating the Effect. Wisconsin will carefully monitor any statewide initiatives or efforts that are likely to affect measurement and analysis in this area. In particular, Wisconsin will monitor the various outreach activities such as the mass mailing that the Social Security Administration (SSA) will be performing and the intensive recruitment of people for this program being done by the local service and advocacy agencies. It will be important to monitor enrollment levels in both the demonstration, and equally importantly, among the regular Medicaid non-demonstration aged population and to see if enrollment trends appear to be sensitive to these outreach efforts.

Hypothesis, Outcome Measures, Data and Isolation of Effect – Budget Neutrality

Budget Neutrality Hypothesis. *There will be no increase in the costs of Medicaid services for the elderly (including the new SeniorCare benefit) over what would have been expended in Medicaid services for the elderly in the absence of the new benefit.*

Increasing access to prescription benefits will increase the quality of primary care and decrease adverse health outcomes associated with the lack of proper and sufficient medications for this population. It is expected that outlays incurred by providing this benefit will be offset by the savings generated from fewer hospital and nursing home stays (and other home health/long-term care services) and a possible decrease in emergency room services associated with improper patterns of medication usage.

Budget Neutrality Outcomes. The outcome that will be measured to assess budget neutrality is as follows:

- All Medicaid aged expenditures plus the demonstration expenditure on behalf of people with incomes at or below 200% FPL will be no higher than the estimated expenditure for Medicaid expenditures without the demonstration as submitted to CMS at the outset of the demonstration.

- A certain proportion of people who would otherwise have enrolled as Medicaid aged will be "diverted" away from the program by improved health or longer avoidance of deteriorating health. (For more detail on this expected outcome, see the "Health Improvement Hypothesis" below.)

Budget Neutrality Data. The data that will be used to measure budget neutrality is as follows:

- Based on prior history and known changes in factors expected to impact the enrollment and costs for the Medicaid aged population, estimates have been developed of the overall cost and enrollment for the five years of the SeniorCare demonstration project. These include the expected costs of Medicaid for the aged without the demonstration, the expected costs of Medicaid for the aged with the demonstration and the demonstration itself.

- Wisconsin will monitor annual Medicaid expenditures and enrollment for the aged population including the demonstration. These amounts will be compared on an annual basis and in the aggregate to the projections made at the outset of the program.

- Wisconsin will report and analyze all Medicaid expenditures on behalf of people aged 65 and older plus all SeniorCare expenditures for people with income at or below 200% FPL.

Isolating the Effect. In terms of isolating the effects of the demonstration, the budget neutrality hypothesis is based strictly on direct measurement, and no isolation of effect strategies will be required. For the section on isolating the effect with respect to "diversions" see the health improvements hypotheses below.

Hypothesis, Outcome Measures, Data and Isolation of Effect – Health Improvement

Health Improvement Hypothesis. The pharmacy benefit will improve the health of the participating elderly population.

Overall health is difficult to quantify precisely and accurate measurement of the health benefits associated with the demonstration is complex and difficult. Wisconsin will use a combination of measures and strategies to shed light on this important area. These strategies include reporting relevant results from the Wisconsin Family Health Survey, providing measures of the rate of hospitalizations and utilization of other institutional health services. In addition, a *post hoc* analysis of the state's drug utilization review system will provide evidence of medication problems averted. This latter exercise will also contribute toward the requirements in the Operational Protocol relating to quality, section (j).

Health Improvement Outcomes. The health outcome proxy measures and their relationship to the desired outcomes are:

- *Self-Reported Health:* The expected outcome would be an improvement over time in self-reported health measures for the Wisconsin aged population, particularly in areas where pharmaceutical services are known or thought to be particularly effective.

- *Health Services Utilization:* Improved health resulting from better access to prescription drugs is expected to be associated with reduced use of inpatient hospital services, nursing home care and associated medical services provided to the aged population. Wisconsin, therefore, will monitor pre- and post- demonstration inpatient hospital, nursing home utilization data and other medical services for this population. Rates will be age-sex adjusted to standardize the SeniorCare population to the state age-sex distributions.

- *Drug Utilization Review:* SeniorCare will be operated through the same agency and systems that provide drug claims processing for the state's Medicaid program. This system has many advanced features to ensure quality and to prevent unsafe or fraudulent prescribing behavior. Key among these is the drug utilization review system (DUR) which is designed to provide both a prospective and retrospective review of prescription claims. Any prescriptions that appear unsafe or otherwise unwarranted are flagged through a real-time point of sale computer system that looks for potential drug-drug interactions, age/gender/drug combinations that appear clinically problematic or evidence of inappropriate drug purchasing patterns.

  For the above three anticipated outcomes, the improvements in the utilization of non-pharmacy health services that can be associated with the demonstration are the "diversions" that are referenced in the section on budget neutrality.

Health Improvement Data. The data that will be used to test this hypothesis is as follows:

- *Self Reported Health:* The data for this section will come from the Wisconsin Family Health Survey, an annual survey that tracks important health related information for Wisconsin household residents. The data elements available from the survey include perceived health status, physical and other health related limitations among adults, chronic conditions among adults, the use of selected health services. For each of these measures there are age breakdowns that permit the measurement of changes over time for the aged population in isolation. In addition to the standard measures listed above, starting in 2002, five questions were added to the survey pertaining to senior's prescription drug access and utilization. These questions cover the proportion of seniors requiring and using prescription drugs, the cost impact of purchasing the medicines, instances of failing to purchase the full prescription or giving up other basic necessities due to costs, the proportion of benefits covered, and finally, knowledge of the demonstration itself.

- *Health Services Utilization:* Utilization rates, in particular the use of institutional services, including nursing homes and acute care facilities, will be used to indirectly measure the health outcomes of the waiver participants. Medicare and Medicaid data will be obtained to measure health services utilization rates associated with acute and chronic diseases particularly amenable to treatment with medication. Changes in these rates over time, and changes in the rates for Wisconsin residents with the pharmacy benefit will be compared over time to low-income seniors in other states that do not have a prescription drug program to evaluate the program's effect. Analysis and data tracking in this area is contingent upon receiving Medicare data for Wisconsin residents from CMS.

- *Drug Utilization Review:* A *post hoc* analysis of the drug utilization review process will collect evidence of the number and type of potential medication problems averted. Summary reports and estimates of the aggregate impact, both clinically and financially, will be developed.

Isolating the Effect. In terms of isolating the effects of the demonstration for this hypothesis, different strategies must be applied for each of the three data sources. For the self-reported health and health services utilization, the effect will have to be estimated. Certainly the known scale of the demonstration will provide some guidance for this, as will the information on access to prescription drugs mentioned in the access section above. For the drug utilization review (DUR) analysis, this is a direct measurement of program participants, and isolation efforts will not be necessary.

Components of the of Health Improvement section of the evaluation, in particular, the DUR section may also be used to satisfy the requirements of the quality section (number 23-j in the operational protocol).

M. INTERACTION WITH OTHER FEDERAL AND/OR STATE PROGRAMS

Medicare

Medicare beneficiaries who apply and meet the eligibility criteria will be enrolled in SeniorCare. This includes individuals who receive benefits from any of the Medicare savings programs (QMBs, SLMB, etc.). SeniorCare will fill the current gap in Medicare coverage for prescription drugs.

Medicaid

Medicaid recipients are not eligible for SeniorCare. Any SeniorCare cost-sharing payments made by such persons may be counted toward their Medicaid spenddown amounts. In a period of Medicaid eligibility, the State will claim only under the Title XIX State Plan, not under the demonstration, for the services provided. (Refer to Section I for additional information.)

According to state law governing SeniorCare, SeniorCare is the payer of last resort. Therefore, to the extent to which persons enrolled in the following programs also

participate in SeniorCare, the waiver program will coordinate benefits with these programs and reimburse only for SeniorCare-allowed prescription drugs not covered by those programs.

Ryan White Care Act Program

The AIDS Drug Reimbursement Program will remain a payer of last resort. The Division of Public Health cross-matches with the Medicaid data base for Medicaid eligibility. This data base will include the individuals covered under the demonstration. Currently, there are less than five individuals enrolled in ADRP. It is expected that there will be very few AIDS patients in SeniorCare.

Chronic Disease

The Wisconsin Chronic Disease Program (WCDP), a state-only funded pharmacy program, offers assistance to Wisconsin residents with chronic renal disease, hemophilia, and adult cystic fibrosis. The WCDP is funded entirely by state dollars. The program pays health care providers for disease-related services and supplies provided to certified Wisconsin Chronic Disease Program recipients after all other sources of payment have been exhausted.

Chronic Disease Program recipients are responsible for certain co-payments and annual deductibles determined by the program. Recipients whose annual income exceeds 300 percent of the federal poverty level must pay a certain percent of out-of-pocket expense before becoming eligible to receive WCDP benefits. The state seeks repayment of WCDP benefits provided to recipients under the Estate Recovery Program.

WisconCare

The WisconCare program, available in certain counties, pays for some primary care office visits, lab tests, x-rays, diagnostic procedures, inpatient maternity care, medical supplies, most prescription pharmaceuticals, insulin drugs, diabetic supplies, and family planning supplies. Only certain health care providers in selected counties participate in the program.

Wisconsin Well Woman Program

Well Woman provides preventive health screening services to women with little or no health insurance coverage. Well Woman pays for mammograms, pap tests, and certain other health screenings. The program is administered by the Wisconsin Department of Health and Family Services, Division of Public Health, and is available in all 72 Wisconsin counties and 11 tribes. Well Woman pays for certain screenings for some of the most common women's health concerns.

Health Insurance Risk Sharing Plan (HIRSP)

The Wisconsin Health Insurance Risk Sharing Plan (HIRSP) offers health insurance to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market. HIRSP covers major medical and prescription drug expenses.